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Fifteen years of Multiprofessional Residency in Family Health at Primary Health Care: contributions from Fiocruz

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Abstract *This article aims to present the experience of 15 years of the Family Health Residency Program of the Sérgio Arouca National School of Public Health (ENSP/Fiocruz) in the city of Rio de Janeiro-RJ, and seeks to identify the challenges and potentialities of the training process of preceptors facing the development of resident training programs. Presents one of its effects that resulted in the contribution with the development of a multiprofessional residency program in partnership with the Municipal Health Department of Campo Grande-MS. Seeks to identify the challenges and potentialities of preceptors training process in the face of the development of training programs for residents. From a theoretical point of view, it presents as cross-cutting questions, multiprofessionality, interprofessionality and the relationship between field and nucleus in the formation of residences in the health professional area. Concludes by pointing out the challenges contained in the practice of the preceptorship of the ENSP program and how they can be implemented in the project of Campo Grande, as well as a new trend for cooperative education institutions for the current model of expansion of residences with the unit offeror to the municipal health departments.*

Key words *Primary Health Care, Residence, Preceptorship, SUS*

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Introduction

Primary Health Care (PHC) in Brazil remains a challenge for some of the managers regarding the expansion, financing, and work process qualification of the management and care[1-3], as well as the need to train specialist professionals who know to manage the most common everyday situations in a PHC service, but not less complex, when compared to other health services. It is about this aspect of the need for specialized training in PHC that health residencies are presented as an important resource, aiming to overcome this unequal training offer in the country.

Considering this understanding, Fundação Oswaldo Cruz (Fiocruz), a public health institution dedicated to teaching, research, and care, prioritized the need for this type of training, constituting since 2005 one of the first multiprofessional residencies in Family Health through the cooperation of *Escola Nacional de Saúde Pública* (ENSP) and the Municipal Health Secretariat of Rio de Janeiro (SMS RJ, *Secretaria Municipal de Saúde do Rio de Janeiro*).

The Multiprofessional Residency Program in Family Health (PRMSF, *Programa de Residência Multiprofissional em Saúde da Família*) ENSP/Fiocruz, has already trained 313 graduates in seven professions (nurses, dentists, nutritionists, social workers, psychologists, pharmacists and physical education professionals), who occupy strategic functions, both in the field assistance and in the management of primary care services and systems in the different spheres of the government.

Although in scenarios of little investment regarding the expansion of the Family Health Strategy (FHS) teams, the PRMSF remained present with offers of annual classes. The little investment in PHC was constant, except in the period between 2009 and 2017, when the city of Rio de Janeiro[3] had a significant expansion, starting from 3.5 to almost 70% of FHS coverage. This happened through the search for more partnerships to expand the growing demand for an organized care model based on PHC. In the following management, there is an inflection of investments and the coverage decreased again and reached coverage levels of 39.63% of the Rio de Janeiro population in June 2020.

Currently, part of the health residencies in the PHC area in Brazil, whether for physicians or of multiprofessional profile, have as their proponent institutions the SMS themselves, justified by the encouragement of funding programs such as the Pro-Residency of the Ministry of Health (MH). However, this process often requires technical support from educational institutions regarding the educational management process.

The PRMSF-ENSP/Fiocruz emerged as a demand from a group of FHS workers in the city of Rio de Janeiro concerned with the incipient PHC coverage, location and the fragile qualification of network professionals in that period, which follows the synergy of the beginning of a policy aiming to expand residency programs in the professional health area, stimulated by the Work and Health Education Management Secretariat (SGTES, *Secretaria de Gestão do trabalho e da Educação na Saúde*), which made it possible to implement this educational offer. In addition to this context, there is the perspective of contributing to the management of Primary Health Care in the development of the FHS in urban and vulnerable areas[4].

The training aimed to reach different professional categories with a degree of qualification in three areas of competence: organization of the work process, health care from the perspective of the expanded clinic (individual, collective and family) and socio-political training, education and health. For the development of these competences, the pedagogical proposal is based on constructivism, problematization, shared construction of knowledge and popular education as methodological references of the learning process praxis. In this sense, the pedagogical project of the RMSF/ENSP[5] sought to organize it from some references such as:

. Curriculum based on professional skills and interprofessional work;

. Problematization of reality by producing local intervention actions guided by popular education;

. Integration of training and work in a single in-service education process;

. Teaching-learning process centered on the resident;

. Learning units aiming to promote professional skills;

. Development of reflective professionals.

The training of the multiprofessional and interprofessional team involved the strategy of grouping residents into 5 teams with different categories. This team of residents is part of a team of preceptors at the Family Clinic identified as a preceptorship Clinic that remains linked to this practice scenario for two years of residency. Understanding that all professionals who work there are potential educators and develop educational processes. A field preceptor monitors

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and coordinates the on-the-job training of the FHS, working as a field preceptor, whereas monitoring of the specific learning for each specialty is performed by the preceptor category, many of which are from the Extended Family Health Nucleus (NASF-AB, *Núcleo Ampliado da Saúde da Família*). The residents participate in category supervision processes that take place on a monthly basis with a professional considered to be highly competent to follow a group of resident professionals in the same category. Here, the field and nucleus concept described by Campos[6] is used.

One of the main objectives of this training is to understand and exercise the multiprofessional practice in the interprofessionality praxis. According to the ENSP proposal, multiprofessionality is more than joining two or more categories in the intervention or training scenes. It is "a modality of collective work, established through the reciprocal, two-way relationship, between multiple technical interventions and the interaction of professionals from different areas constructed through communication" as pointed out by PeduzzI[7]. According to Ceccim[8], the concept of Interprofessionality refers to the intersection of professions, therefore, to what is common to more than one profession; "Inter within two; in the common space of two; a crossing/link/connection point". The concept of professionality, on the other hand, concerns the characteristic of what is professional, the professionals' distinctive procedure (their way of seeing and acting) and their professional competence (knowledge, skill and responsibility).

Ellery[9] identifies three dimensions of challenges: the *organizational* dimension, in the structuring of a school health network, the *collective* dimension, in the organization of professionals as a work group, and in the *subjective* dimension, where learners can identify themselves with the model, know how to deal with frustrations and promoting affections in the act of working. For the author, these are challenges for constructing the learning that training institutions must face to develop interprofessional practice. Interprofessional training allows the creation of multiprofessional meetings and the performance of actions that can be performed by all health workers in a shared and common practice. They often carry out common practices and interventions, or even of their category, incorporating knowledges from other professional nuclei in a clear articulation between field and nucleus of knowledges[9].

When understanding the coordination of the RMSF/ENSP so that interprofessionalism can occur, it is necessary to have an inter-relationship and interaction in shared construction dynamics of the knowledge, information and practice developed in relations of interaction, cooperation and production of autonomy[10]. Realizing the expansion of the common field of knowledge and the "blurring" between the boundaries of each profession is the identification of a training that shares clinical practice, expanding its scope of action, but also the reflective capacity of its residents in moments of interaction and cooperation.

Against the difficult reality of many programs, the PRMSF recognized the need to qualify its preceptors since the first offer, aiming at the pedagogical training of health network workers in health units that would be configured as practice scenarios. By identifying that the network does not always provide conditions to assume, in addition to user care activities, the training of new resident workers. The presence of residencies in these services made it possible to expand the network qualification and increase the possibility that SUS would exercise this formative role, in addition to what brings the workers the need to qualify as a multiplier effect. Several preceptors sought to carry out specialization courses or in *stricto sensu* programs (master's and doctorate degrees), thus allowing the incorporation of new pedagogical and assistance strategies aiming to create intervention processes in practices, in research and care actions caused by the performance of residents in the network.

It is about this articulation between municipal management and Fiocruz throughout these 15 years in the management of PRMSF that at the end of 2019 the municipality of Campo Grande identified the need for expansion and qualification of its PHC network and sought to establish partnership through cooperation with Fiocruz and the MH. This resulted in the development of an initiative aimed at this purpose called the Primary Health Care Innovation Laboratory (LABINOVAAPS, *Laboratório de Inovação de Atenção Primária em Saúde*)[11], being coordinated by a professional with previous experience as a former manager of SMS-RJ during the period of greatest growth in PHC coverage. This experience made it possible to understand the need for the inclusion into the training axis the proposal for residency training in family and community medicine and multiprofessional residency in the FHS. This initiative aimed at providing technical support for the following items: development of

the pedagogical project; programmatic construction; creation of the pedagogical tools; development of the selective process for residents and preceptors and the preceptors' training process.

As a result, some areas of Fiocruz were mobilized for this support, such as the office management of Fiocruz Mato Grosso do Sul, the general coordination of residencies linked to the Vice-Presidency of Education, Information and Communication (VPEIC, *Vice-Presidência de Educação, Informação e Comunicação*) and particularly the management of the RMSF/ENSP considering its experience trajectory in part already presented herein. It is important to highlight that until 2019, Fiocruz had a tradition of being exclusively a unit that offered its own residency programs, with this scenario being modified as of this cooperation, which may point to a new trend of the new educational offers.

The main objective of this article is to present the experience of 15 years of PRMSF/ENSP, pointing out and analyzing the challenges contained in the preceptorship practice. As a consequence of this experience, present the potential of the partnership with a new program in the municipality of Campo Grande with an emphasis on the training of preceptors.

Methodology

The proposal is characterized as an experience report of an ENSP multiprofessional residency program that has existed for fifteen years in the municipality of Rio de Janeiro under the commitment of contributing to PHC qualification in a situational perspective and the development of a new program in the municipality of Campo Grande. This experience enabled an exercise to involve the observer in relation to the object and its surroundings and as an application project proposal.

This work is characterized as a qualitative descriptive approach because it is concerned with a level of reality that cannot be quantified. However, it interacts with quantitative data, understanding that they can establish complementarity and not dichotomy[12], using documental analysis associated with participant observation, as it is understood that they are techniques that complement each other in relation to the studied phenomena. The documental analysis favors the observation of the evolution process of the context being analyzed: projects, individuals, groups, concepts, knowledges, behaviors, practices, among others[13]. In this methodological perspective, the documents of curriculum construction, regulations, pedagogical project, curriculum of the training course for preceptors of the two programs, *Coremu* minutes, books, indexed magazine articles related to the topic, public websites and written records were used as sources.

The on-screen audience were the actors of the training process and the 44 preceptors of the new PRMSF Campo Grande, in which the produced analyses were not intended to exhaust the topic, but rather to foster a critical and reflective look at the training of preceptors in residents' qualification.

Context for carrying out the programs

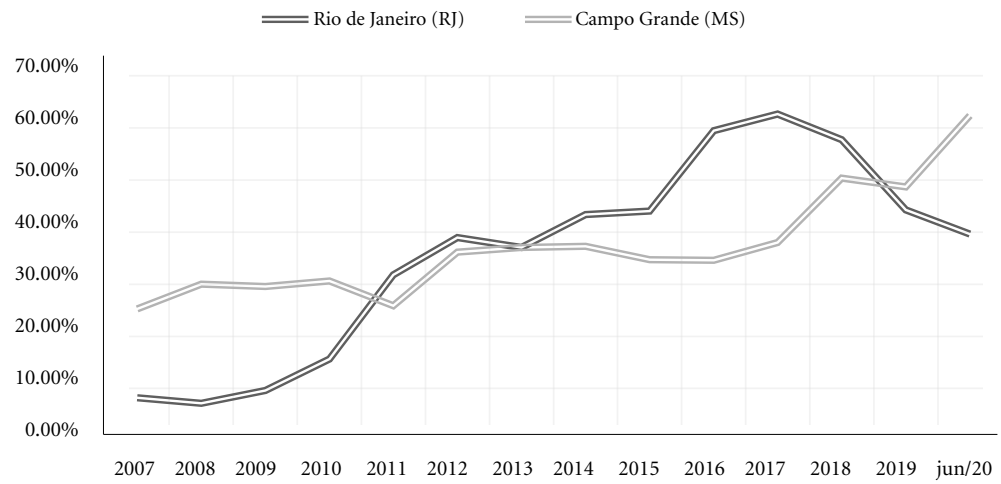
Campo Grande is a large municipality and the capital of the state of Mato Grosso do Sul. According to the census/IBGE/2010, it has 786,979 inhabitants with an estimated 895,982 inhabitants in 2019. From the point of view of ethnicity, 50% of the population declared themselves white, 47% brown and black, 0.7% indigenous and 1.7% yellow. The Municipal Human Development Index of 0.784 is considered high according to the PNUD 2014 classification. The Municipal Health Secretariat (SESAU) has a primary care network comprising 16 Basic Health Units (BHU), 53 Basic Family Health Units and 12 ENASF teams. Health services are structured in full management of the system at all levels of care: primary, secondary and tertiary[14].

Graphs 1 and 2 show the two municipalities at very different times in terms of coverage of both the FHS and primary care.

It is possible to identify that the two cities live in different contexts when related to PHC coverage. Rio de Janeiro, which had 62.68% of FHS coverage in 2017, decreased to 39.63% in 2020, that is, a loss of 23.05% of coverage. Whereas in Campo Grande the opposite occurs, with an increase of 24.39%, going from 37.99% in 2017 to 62.38% in 2020. This allows the municipality of Campo Grande to provide the opportunity to develop innovations in the PHC field, including the possibility of expanding training scenarios into the Midwest region[15].

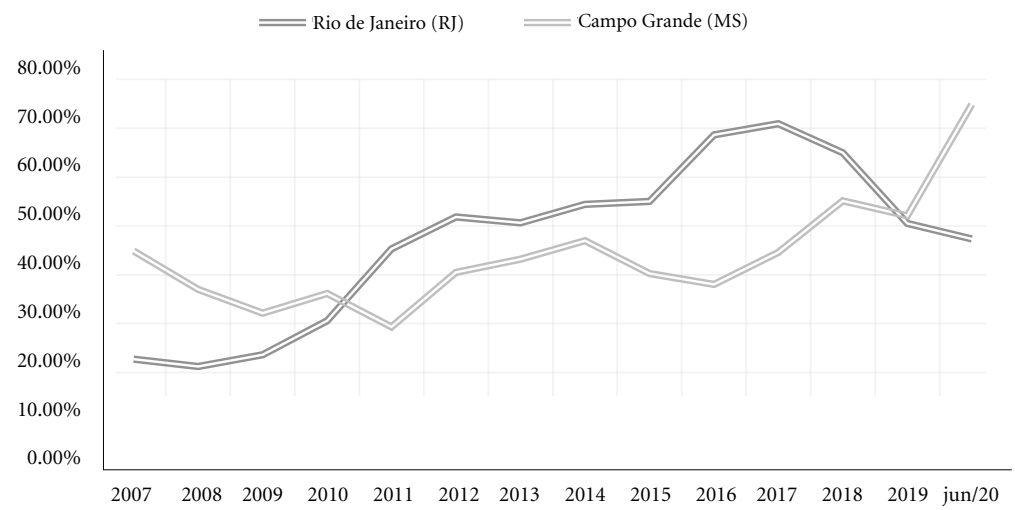
The challenge of SUS-School

In a recent opinion article sent to *Revista Consultor Jurídico*, lawyer and professor Lenir Santos[3], from UNICAMP, states that health underfunding had already reached high levels in the last ten years, with only R$ 3.60 per capita/



Graph 1. Family Health Strategy coverage in the municipality of Rio de Janeiro-RJ and Campo Grande-MS, in the period of 2007 to 2020.

Source: MS/SAPS/Department of Family Health (DESF) Geographic Units: Brazil. (https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xhtml, accessed on 08/19/2020).



Graph 2. Primary Care coverage in the municipality of Rio de Janeiro-RJ and Campo Grande-MS, in the period of 2007 to 2020.

Source: MS/SAPS/Department of Family Health (DESF) Geographic Units: Brazil. (https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xhtml, accessed on 08/19/2020).

day. For her, these values no longer supported the Brazilian public health system. It got worse with Constitutional Amendment n. 95, of December 15, 2016, called expenditure ceiling amendment, because it froze the resources for health and education for 20 years. For her, this process may institute a predatory dispute over the federal budget between municipal and state entities. The same author does not see any problems in the legal framework of SUS; however, she identifies that the training of SUS health workers is still an agenda to be faced, although provided for in the Federal Constitution (FC)[16].

Throughout the 32 years of SUS existence, the premise of ordering health education has not been fully consolidated. This did not define a direct relationship between the set of guidelines for the qualification of these professionals and the public health network. Articulating training scenarios and work spaces has been a constant search for the Ministry of Education (MEC, *Ministério da Educação*) and the Ministry of Health (MH).

The National Curriculum Guidelines (NCG)[17] should act as parameters for changes in the training of professionals for a new health model. Some proposals for changes are directed to this framework, such as: training by professional skills, shifting the focus from the disease to health, balancing individual and collective care, expanding multiprofessional team work, developing permanent education in the work context and, as a pedagogical strategy, using methodologies based on problem-solving and supported by scientific evidence[17], as structuring parts of the pedagogical project.

The training system has shown itself to be insufficient to qualify for PHC, both at the medium level and at the specialized technical level. Despite some initiatives promoted by SGTES/MS since 2005, such as the Permanent Education Policy, Popular Education and Health Policy and programs such as VER-SUS, Promed, Pro-Saúde, Pet, Provab, *Mais Médicos*, GraduaSus, Prof-Saúde and the incentive to residencies[18].

Multiprofessional residencies in health have been part of this challenge of the network qualification from the perspective of permanent education since 2005, when Law n. 11,129 of June 30, 2005, was established, instituting the *Pró-jovem* (Pro-youth) program and creating residencies in the professional area health, except the medical area[19].

Given the above, three major challenges can be listed, which the training system has faced and that needs to mobilize actions:

1- To think processes that articulate work and training without one preceding the other. It needs to develop pedagogical processes that value the different knowledges developed in this interprofessional relationship and promote the valuing of knowledge in the practice of health services. To recognize that in the work of a team, shared knowledge and actions are developed in the daily construction of health care.

2- To perceive educational acts in life, in the experiences with health and illness, in cases and situations of real problems in which reflections on the experienced situations can contribute to meaningful learning. Learning that makes sense to the learner and allows new types of knowledge to be anchored in previous knowledges and be related to real-life situations. For that purpose, it needs the articulation of scientific knowledge with the knowledge of common sense, the recognition of the circulating knowledge in the actors' experience.

3- To think about training aiming to develop pedagogical processes that promote care for the life of the planet, the city, the neighborhood, the territory, the collective, the self and the other. This training needs to be developed from the perspective of the humanization of care, the production of care acts, of accountability and involvement with the needs of those who are cared for, in the production of attitudes of care, which are involved in individual and collective projects in the search for the union of work with care.

Challenge of the legal framework of residencies

Residencies in the Professional Health Area aim to qualify young professionals for inclusion into SUS through; intersectoral cooperation – joint responsibility of the education and health sectors; exclusive dedication regime of contracting; strategies for offer and fixation of professionals in programs, projects, actions and activities and in priority regions for SUS.

For many years, the training of residencies in the professional health area (multiprofessional and uniprofessional) titled their graduates as a 360-hour *lato sensu* postgraduate course, called "Specialization in the molds of residency". However, residency programs in the health professional area developed and still develop their curricula with a workload of 5,760 hours, comprising 60 hours per week.

The National Commission of Multiprofessional Residency in Health (CNRMS, *Comissão*

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Nacional de Residência Multiprofissional em Saúde) was regulated by Interministerial Ordinance n. 45, of January 15, 2007, later replaced by Interministerial Ordinance MEC/MH n. 1,077, of November 12, 2009[20]. Only more than ten years later, CNRMS published Resolution n. 7 of November 13, 2014[21], which made it possible to validate the course completion certificates as a Residency.

SGTES-MH in 2005, supported 22 Residencies for believing in the pedagogical and political potential of Residencies in the redefinition of the SUS technical-assistance model. Currently, MEC and the MH together finance more than 2,200 residency programs in the professional health area (SGTES/MS) and (SESu/MEC - 2019).

Through a search for information in MEC, it was possible to identify that, in 2019, the residencies already included a total of 2,239 people, of which 1,118 were multiprofessional and 1,093 were uniprofessional individuals. The information shows out that among these 230 programs did not have a link with a training institution. Figure 1 shows that 215 programs were excluded due to lack of information on both the city and the state. The SINAR/MEC system proved to be difficult to access and insufficient regarding the presentation of consolidated information, which made it impossible to produce new analyses[22]. However, it is important to identify the growth of programs that are not linked to educational institutions and that are capable of constituting themselves as an institution that proposes residency programs, with a large part of them linked to health secretariats and/or public health schools.

The LABINOVAAPS project aims to expand the offer of programs in the Midwest and the role of Fiocruz in this process of democratizing the offer of multiprofessional residencies. To think of a training network that aims to contribute to the transformation and improvement of the organization of health work and that integrates health workers as subjects of knowledge, it is necessary to reflect on how the preceptor is constituted.

Preceptorship and functions

For this training, the preceptor is understood as a teacher, advisor, facilitator and conductor of the learning process; it is the preceptor's responsibility to generate hypotheses, to stimulate critical reflection and guide activities that articulate training and the exercise of work. It is understood that human training is intentional and does not end with the action of one subject over the other, not even in the act of teaching, since no one – however prepared they might be – is able to educate the other, to supply them with what is lacking or what they need for their full training.

Resolution n. 2 of the CNRMS, of April 13, 2012[23] shows that the preceptor's role is characterized by direct supervision of the practical activities carried out by residents in the health services where the program is developed, performed by a professional linked to the training or performing institution, with minimal specialist training. The preceptor must necessarily be from the same professional area as the resident under their supervision, being present in the practice scenario.

The supervision of a preceptor from the same professional area does not apply to programs, areas of concentration or internships focused on activities that can be performed by any health professionals qualified in the specific area of activity, such as: management, workers' health, epidemiological, environmental or sanitary surveillance, among others.

This teaching practice requires facing and solving challenges inherent to human relationships, subjectivities, territorial dynamics, management, organization of services, training of each professional category, evaluation processes, permanent education and the mastery of other contents and care practices that coexist as guiding axes of this teaching action.

Results

As previously mentioned, SESAU, in addition to the cooperation already established with local universities for the qualification of its workers, also decided to expand the partnership for residency with Fiocruz Mato Grosso do Sul, beyond the already recognized expertise with the offer of *stricto sensu* postgraduate programs, specialization courses and free professional qualification courses included in the distance learning modality.

It is important to highlight that the offering unit accredited by MEC is SESAU, which identified the need to form a team responsible for the development of the new program, given the volume of vacancies (77) and the restricted implementation time articulated with the other PHC qualification initiatives in the municipality. Therefore, the management team was in charge of: General coordination of the residency program - 1 technician indicated by the co-

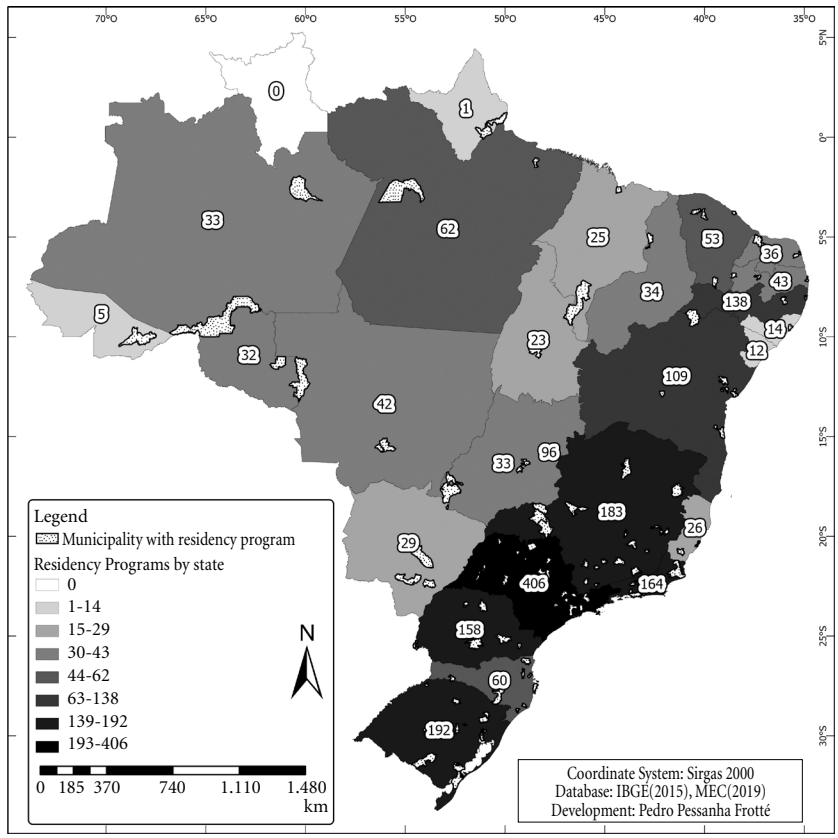

Figure 1. Distribution of Residency Programs in the Professional Health Area (multiprofessional and uniprofessional) in the states of the country, Brazil, 2019.

Source: IBGE (2015) and MEC (2019).

ordination of LABINOVAAPS supported by 2 technicians indicated by SESAU; Pedagogical coordination - 3 technicians from Fiocruz, 1 from Fiocruz Mato Grosso do Sul and 2 more from Fiocruz Rio de Janeiro; Thematic supporters - 3 technical consultants with previous experience in SMS RJ; Preceptors - professionals from SESAU family health teams.

Regarding the support to the preceptors' training process, it is necessary to remember the stage about their selection process. These were initially submitted to a curriculum selection and interviews coordinated by this management team, whose main objective was to identify the candidate's availability to compose a technical reference profile, articulating the functions of nucleus and field of competencies, teamwork and to be an educator, which implied studying and learning with the others.

Many workers applied for this selection process and what can be said is that selecting preceptors in this manner is not common in most programs, since the preceptor function ends up being attributed according to the manager's indication or even to those professionals who are on duty when there is a resident in practical activity.

Another interesting aspect was the ratio of 2 preceptors for 1 resident, as well as the same remuneration as the resident's scholarship, which certainly favors a differentiated dedication. It is observed that this was only possible through the financing of LABINOVAAPS project as support from the MH, which followed the model already tried in the municipality of RJ.

An introductory 40-hour training course for preceptors was offered to the group of preceptors, held at Fiocruz in Rio de Janeiro under the pedagogical coordination of the ENSP program. This

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training prioritized the three dimensions: pedagogical, technical and ethical/attitudinal. The use of active methodologies utilized themes such as the presentation of the LABINOVAAPS[11] project and the connection with the residency, regulatory framework, the preceptor's competence profile, construction strategies for welcoming the residents, case discussions, visiting the SMS-RJ service network, among others. It is noteworthy that this process was developed based on the experience of the RMSF/ENSP.

With the arrival of the residents in the practice scenarios, new meetings were scheduled with the preceptors following the perspective of permanent education, with topics such as listening to the local context of the units' structure and support from SESAU, the expectations and planning of the first weeks while welcoming the residents. The interesting thing about these first meetings was also the fact of developing the distinction of the dual role of preceptors and members of the health teams with this group. For the team of the residency general coordination, also the distinction between the challenge of being educational managers and not supporters of the SMS management.

An interesting aspect is to recognize that the preceptors' training processes did not happen exclusively during the meetings with the pedagogical coordination. They also took place during the several meetings proposed by the general coordination of the program and in the relationship with the residents themselves.

With the arrival of the COVID-19 pandemic, the meetings started to be held using the remote modality, with emphasis on the preceptors' tutoring function, together with the on-site residents, offering activities in Distance Education (DE) to continue the first part of the program content. At the same time, permanent education meetings were always prioritized with topics brought up by the group itself, together with offers always articulated with the need for general coordination. Such as the construction of assessment references for residents, as well as the dimensions of the core competences of each preceptor, that is, training that values the field and nucleus training too.

Final considerations

It is possible to affirm that some gains in this ongoing process can be identified, the first being that there is a tendency to be better observed, not only for Fiocruz, regarding this initiative of cooperating with other SUS institutions, in the perspective of not necessarily being the proponent manager to MEC, but creating new possibilities for cooperation in other fields, in the case of educational management, selection process etc. And this experience can undoubtedly be fully applicable by other educational institutions such as Fiocruz, with a particular interest in contributing to the expansion and qualification of PHC residencies.

As the second aspect, one can observe that the experience accumulated in the educational management of PRMSF/ENSP has shown to be powerful in facilitating cooperation with a new training program. Especially at this point in the initial stages in the development of the new program.

The third aspect is the commitment to work with technical and financial support, which allows investments in the permanent training of preceptors, both from the point of view of attributions and in the organizational aspect, which facilitates their hiring and their motivation. Perhaps, the challenge may lie in how to sustain similar initiatives without financial support, as in this case for the payment of scholarships for preceptors.

Finally, it should be noted that this experience of preceptors' qualification must be fully articulated with the municipal health management project, aiming at the greater purpose of recognizing training as a powerful resource for PHC qualification, with the objective of providing care by not reproducing a successful model but customizing it according to the local needs.

Collaborations

MAP Carvalho worked on the design, research, methodology and writing of the final version of the manuscript. AC Gutiérrez worked on the methodology, analysis and writing of the final version of the manuscript.

References

1. Carvalho M, Santos NR, Campos GWS. A construção do SUS e o planejamento da força de trabalho em saúde no Brasil: breve trajetória histórica. *Saúde Debate* 2013; 37(98):372-387.
2. Brasil. Ministério da Saúde (MS) [Internet]. [acessado 2020 ago 20]. Disponível em: http://www.saude.gov.br/sistema-unico-de-saude.
3. Santos L. *SUS: reformar é mesmo preciso?* [Internet]. [acessado 2020 ago 12]. Disponível em: https://www.conjur.com.br/2020-ago-12/lenir-santos-sus-reformar-mesmo-preciso?imprimir=11/5.
4. Soranz D, Pinto LF, Penna GO. Eixos e a Reforma dos Cuidados em Atenção Primária em Saúde (RCAPS) na cidade do Rio de Janeiro, Brasil. *Cien Saude Colet* 2016; 21(5):1327-1338.
5. Programa de Residência Multiprofissional em Saúde da Família (PRMSF). Escola Nacional de Saúde Pública Sérgio Arouca (ENSP). Fundação Oswaldo Cruz (Fiocruz). *Projeto Político Pedagógico do Programa de Residência Multiprofissional em Saúde da Família*. Rio de Janeiro: ENSP/Fiocruz; 2007.
6. Campos GWS. Saúde pública e saúde coletiva: campo e núcleo de saberes e práticas. *Cien Saude Colet* 2000; 5(2):219-230.
7. Peduzzi M. Trabalho em equipe. In: Pereira IB, Lima JCF. *Dicionário da educação profissional em saúde*. 2ª ed. rev. ampl. Rio de Janeiro: EPSJV; 2008.
8. Ceccim RB. Conexões e fronteiras da interprofissionalidade: forma e formação. *Interface (Botucatu)* 2018; 22:1739-1749.
9. Ellery AEL. *Interprofissionalidade na estratégia saúde da família: condições de possibilidade para a integração de saberes e a colaboração interprofissional* [tese]. Fortaleza: Universidade Federal do Ceará; 2012.
10. Minayo MCS, organizadora. *Pesquisa Social. Teoria, método e criatividade*. 18ª ed. Petrópolis: Vozes: 2001.
11. Centro de Estudos Estratégicos (CEE). Laboratório de Inovação na Atenção à Saúde (INOVAAPS). *Institucional* [Internet]. [acessado 2020 ago 12]. Disponível em: http://labinovaapsfiocruz.com.br/portal/#/institucional.
12. Carvalho MAP. Construção compartilhada do conhecimento: análise da produção de material educativo. In: Brasil. Ministério da Saúde (MS). Secretaria de Gestão Estratégica e Participativa. *Caderno de Educação Popular e Saúde*. Brasília: MS; 2007. p. 91-102.
13. Cellard AA. *A pesquisa qualitativa: enfoques epistemológicos e metodológicos*. Petrópolis: Vozes; 2008.
14. Brasil. Ministério da Saúde (MS). Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. *Residência Multiprofissional em saúde: experiências, avanços e desafios*. Brasília: MS; 2006.
15. Brasil. Ministério da Saúde (MS). Secretaria de Atenção Primária à Saúde. Departamento de Saúde da Família. *Unidades Geográficas: BRASIL* [Internet]. [acessado 2020 ago 20]. Disponível em: https://egestorab.saude.gov.br/paginas/acessoPublico/relatorios/relHistoricoCoberturaAB.xtml.
16. Brasil. Emenda Constitucional nº 95, de 15 de dezembro de 2016. Altera o Ato das Disposições Constitucionais Transitórias, para instituir o Novo Regime Fiscal, e dá outras providências. *Diário Oficial da União* 2016; 15 dez.
17. Brasil. Resolução CNE/CES nº 4, de 7 de novembro de 2001. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina. *Diário Oficial da União* 2001; 9 nov.
18. Moreira COF, Dias MSA. Diretrizes Curriculares na saúde e as mudanças nos modelos de saúde e de educação. *ABCS Health Sciences* 2015; 40(3):300-305.
19. Brasil. Lei nº 11.129, de 30 de junho de 2005. Institui o Programa Nacional de Inclusão de Jovens – ProJovem; cria o Conselho Nacional da Juventude – CNJ e a Secretaria Nacional de Juventude; altera as Leis nº s 10.683, de 28 de maio de 2003, e 10.429, de 24 de abril de 2002; e dá outras providências. *Diário Oficial da União* 2005; 1º jul.
20. Brasil. Portaria Interministerial nº 1.077, de 12 de novembro de 2009. Dispõe sobre a Residência Multiprofissional em Saúde e a Residência em Área Profissional da Saúde, e institui o Programa Nacional de Bolsas para Residências Multiprofissionais e em Área Profissional da Saúde e a Comissão Nacional de Residência Multiprofissional em Saúde. *Diário Oficial da União* 2009; 13 nov.
21. Brasil. Resolução CNRMS nº 7, de 13 de novembro de 2014. Regulamenta os processos de avaliação, supervisão e regulação de programas de Residência em Área Profissional da Saúde. *Diário Oficial da União* 2014; 17 nov.
22. Brasil. Ministério da Educação (MEC). *Sistema Nacional de Residências em Saúde – SINAR* [Internet]. [acessado 2020 ago 12]. Disponível em: http://sinar.mec.gov.br/primeiro-acesso.
23. Brasil. Ministério da Educação (MEC). Resolução nº 2, de 13 de abril de 2012. Dispõe sobre as Diretrizes Gerais para os Programas de Residência Multiprofissional e em Profissional de Saúde. *Diário Oficial da União* 2012; 16 abr.

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